STATE OF RHODE ISLAND
AND PROVIDENCE PLANTATIONS

OFFICE OF THE HEALTH INSURANCE COMMISSIONER

IN RE: BLUE CROSS & BLUE SHIELD OF :
RHODE ISLAND CLASS DIR :
NOVEMBER 20, 2006 :

PRE-FILED DIRECT TESTIMONY OF THOMAS A. BOYD

Q. Please state your name, title and area of responsibility.

A. Thomas A. Boyd, Executive Vice President ("EVP") of Blue Cross & Blue Shield of Rhode Island ("Blue Cross"). I am one of two EVPs at Blue Cross, and I report directly to the President and Chief Executive Officer. My responsibilities involve management of all aspects of the corporation related to financial services, sales and marketing services, community and employee services and strategic planning services. I have been an EVP of Blue Cross since January of 2005. Prior to that, I had been employed for 18 years with Blue Cross with increasing responsibilities, principally in the underwriting area. Prior to being employed with Blue Cross, I was employed by Blue Cross & Blue Shield of New Hampshire. I am familiar with the internal operations of Blue Cross, and with the presentations made to the Blue Cross Board of Directors and the Finance Committee related to this rate filing. I am the designated operational and policy witness for Blue Cross for this rate filing.

Q. Would you please generally describe who the subscribers are for Class DIR?

A. Yes. Class DIR subscribers are individuals and families who reside in Rhode Island and who are neither eligible for employer based coverage (other than a self employed individual), nor State or federal programs.

Q. What are the products available to Class DIR subscribers?

A. HealthMate Coast-to-Coast Direct Plan 400/800 ("HealthMate Direct 400") offers comprehensive coverage for medical care and prescription drugs. HealthMate Direct 400 has a $20 copay for a visit to a primary care physician and a $40 copay for a specialist visit. There is a $75 urgent care copay and a $200 emergency room copay. These copay levels are designed to incent members to obtain services at the least costly, most appropriate setting. For all other in-network services, a $400 per member/$800 per family deductible is applied, with a 10% member paid coinsurance after the deductible. There is an in-network out-of-pocket maximum of $2500 per member/$5000 per family. Prescription drug coverage is provided at participating pharmacies with a member paid coinsurance of 20% generic/25% brand/and 50% non-preferred brand. Pharmacy coverage does not go toward meeting the deductible. In general, members have a greater expense (i.e., higher deductibles and coinsurance) for services rendered out-of-network. We have seen little usage of out-of-network providers given the very broad network Blue Cross has in Rhode Island. Additionally, the Blue Card® PPO national network administered under the auspices of the national Blue Cross Blue Shield Association provides a comprehensive network for our Class DIR members available throughout the country.

HealthMate Coast-to-Coast Direct Plan 2000/4000 ("HealthMate Direct 2000") coverage is similar to HealthMate Direct 400. The only differences are in the deductible and coinsurance percentages. The HealthMate Direct 2000 deductible is $2000 per member/$4000 per family, and the member paid coinsurance is 20% for in-network benefits.

The HealthMate for HSA Direct Plan 3000/6000 ("HealthMate for HSA 3000") and HealthMate for HSA Direct Plan 5000/10000 ("HealthMate for HSA 5000") products also provide comprehensive coverage for medical care and prescription drugs. These products have deductibles of $3000 per member/$6000 per family and $5,000 per member/$10,000 per family,

respectively. The deductibles apply to all covered services except for certain preventive services. The following selected preventive services do not apply to the deductible and are covered at 100% in-network: Adult and pediatric well visits and immunizations; PAP smears, screening mammography and prostate screening. Prescription drug costs will count toward meeting the deductible. After satisfaction of a member's deductible, in-network benefits are paid at 100% of all covered services. As in the case of the other Class DIR products, members have greater out-of-pocket costs (i.e., a separate deductible and coinsurance) for services rendered out-of-network. And like our HealthMate Direct plans we have seen little usage of out-of-network providers by HealthMate for HSA members given the very broad network Blue Cross has in Rhode Island. The Blue Card ® PPO national network administered under the auspices of the national Blue Cross Shield Association also provides a comprehensive network for our HealthMate for HSA members available throughout the country.

The HealthMate for HSA 3000 and HealthMate for HSA 5000 products are designed to be HSA qualified high deductible health plans (HDHPs) under federal law. These plans permit subscribers to open Health Savings Accounts and set aside pre-tax dollars to fund eligible health care expenses. Blue Cross believes this may be particularly beneficial to those self-employed individuals who chose Direct Pay. While these two plans are designed to be HSA qualified HDHPs, the subscriber need not establish and fund an HSA account in order to purchase HealthMate for HSA 3000 or 5000. In those circumstances, these plans would effectively be higher deductible plan options, without the tax benefits for those subscribers who elect not to fund an HSA. To assist those members who may be interested in opening an HSA, we extend the convenience of our arrangement with Wells Fargo Health Benefit Services ("Wells Fargo"). Blue Cross members get competitive rates for the administration of HSA's through Wells Fargo; however, they may choose to open an HSA at any qualified financial institution.

Q. Does Blue Cross intend to establish a relationship with Blue Healthcare Services as part of the services available to HSA customers?

A. Yes. The Blue Cross Blue Shield Association is in the process of establishing Blue Healthcare Services for the purpose of administering consumer spending accounts and to provide a qualified custodian for Health Savings Accounts. Blue Healthcare Services will be operational as early as January 2007. It is our intent to establish a relationship with Blue Healthcare Services no earlier than January 2008, pending that it will meet our needs and several business requirements. Blue Healthcare Services will offer an FDIC insured savings account option to Health Savings Account customers. This includes both group and individual customers. We will inform our members when this option becomes available. However, members will still have the option to choose to open an HSA at any qualified financial institution.

Q. Is there more than one rate structure for Direct Pay subscribers?

A. Yes. For Direct Pay, we have two pricing structures. They are:

Basic Rates (Pool I) which is the regular Blue Cross DIR program with set or community, individual and family rates.

Preferred Rates (Pool II) is a Blue Cross DIR program rated by age and gender and which utilizes a health statement.

We believe it is critical to affordability to continue these pricing structures. It is important to have Preferred Rates (Pool II) in order to continue to encourage healthy individuals to purchase Direct Pay. This is crucial to keeping rates more affordable for all Direct Pay subscribers.

Q. Is there any open enrollment under Basic Rates (Pool I) or Preferred Rates (Pool II)?

A. Yes. Legislation passed in 2004 mandated that Blue Cross conduct an open enrollment annually in the Direct Pay market for Pool 1. Notwithstanding there had been no such prior legislative requirement, Blue Cross was the insurer of last resort for individuals in Rhode Island and traditionally had an annual open enrollment in Direct Pay. No other carrier in Rhode Island offers comprehensive health care coverage to individuals, presumably because they see it as a highly regulated, unprofitable area. Blue Cross alone provides options to individuals in this State for their health care coverage. In addition, the Pool II plans are available to any eligible individual or family who can meet our medical underwriting guidelines throughout the year.

Q. Has Blue Cross recently conducted an open enrollment?

A. Yes. The last open enrollment occurred from August 15, 2006 through September 15, 2006 for an October 1, 2006 effective date. Open enrollment was advertised on BCBSRI.COM as well as in the Providence Journal on August 20, August 23 and August 27, 2006. In addition, individuals who were not eligible to join throughout the year were sent a postcard reminding them about open enrollment. As a result of this most recently completed open enrollment approximately 656 new applications were received with 171 for Basic Rates (Pool I) and 485 for Preferred Rates (Pool II). Subscribers who pass the health screen can enroll at any time during the year into Preferred Rates (Pool II).

Q. Did Blue Cross conduct a full review of the Direct Pay Subscriber packet prior to Open Enrollment?

A. Yes. Blue Cross planned a limited run of marketing materials for the initial enrollment selection period in conjunction with initial entry of the new products on April 1, 2006, anticipating that revisions may need to be incorporated based on member feedback and feedback from the Office of the Health Insurance Commissioner (OHIC). We began the review

and revision process in May of 2006. We incorporated the feedback we received from members through Individual Sales, Customer Service, the four subscriber information sessions held in March, 2006, and the Direct Pay Constituency Advisory Committee. In July, drafts of the revised materials were submitted to the OHIC for review. In August, revised materials were phased into production for Open Enrollment. BCBSRI.COM was also updated with the new brochures.

Q. Please describe how Blue Cross services existing and prospective Direct Pay members?

A. There are two entities within Blue Cross that take questions about our Direct Pay plans, Customer Service, which handles all inquiries from enrolled members and Individual Sales which handles all inquiries from prospective members. Each area has a unique phone number but calls are transferred between departments if a caller ends up in the wrong area. This may increase a caller's wait time but is the best means of ensuring the caller gets to the right source of information. The telephone number and hours of operation for each unit are as follows:

- Customer Service (401) 459-5000 or 1-800-639-2227 (M-F from 8am – 7pm and Saturday from 9am – 2pm)
- Individual Sales (401) 351-BLUE (2583) (M-F from 8:15am – 4:30pm)

Assistance is available over the telephone, on-line through our secure messaging feature on BCBSRI.COM or in person at 15 LaSalle Square, Providence, Rhode Island.

Over the past year both departments have received additional training on the new Direct Pay initiatives launched in April, 2006. The extent of that training was purposely tailored to the types of calls each department is intended to handle.

On March 1, Customer Service launched a dedicated call unit for Direct Pay members. The training for this unit focused on the following:

- The Enrollment Selection Process including the new rates and plans launched in April 2006
- The Premium Assistance Program
- How to answer questions about the out of pocket costs for specific services
- How to help members use the plan selection tool
- What information is posted to BCBSRI.COM

When answering questions about the cost of services, Customer Service representatives are trained to help members first understand if/how a service is covered under their plan (i.e. copay, deductible, coinsurance). When necessary, they also can contact a member's provider to discuss any proposed treatment and, with that information, help provide an estimate of the member's potential out of pocket cost.

There are 7 representatives in Individual Sales who are responsible for helping prospective members understand and enroll in an appropriate individual plan in either the under 65 (Direct Pay) and over 65 (Medicare Advantage, Plan 65) markets as well as individual Dental coverage. For those interested in enrolling in one of our Direct Pay Plans, they provide callers with information about their plan options, eligibility guidelines, how to enroll, and availability of the Premium Assistance Program.

Prior to the launch of the 4 new plans and the Premium Assistance Program last year, Individual Sales training focused on:

- The new plan designs
- The Premium Assistance Program
- How to answer questions about the out of pocket costs for specific services
- How to help members use the plan selection tool

- What information is posted to BCBSRI.COM

When answering questions about the cost of services, these representatives are trained to help prospective members understand if/how a service is covered under each plan (i.e. copay, deductible, coinsurance). Because callers are not enrolled members, information and conversations on this topic are generally more conceptual.

Both the Customer Service and Individual Sales departments have regularly scheduled staff meetings and training classes to handle intermittent training and educational needs. Ad hoc trainings are held as needed for new initiatives. Also, each member of the telephone staff is monitored on a regular basis and provided feedback to ensure that calls are handled properly.

In addition over the past year, Blue Cross has made significant revisions to our Direct Pay Sales Kits. Most recently, we have revised our benefit brochure "Direct to You: A Guide to Your Healthcare Choices" to include a section titled "How to Become a Member." This section explains the enrollment process as well as eligibility guidelines. We have also developed a comparison tool "Choosing the Right Plan for You," which illustrates how our plans work, encourages members to think about how they want to manage their healthcare dollars and includes a worksheet designed to assist in selecting the plan which best suits their needs. We are continually working to improve these materials. This information is available to members on BCBSRI.COM or by contacting Customer Service. Prospective members may view our sales materials online, request a Sales Kit through BCBSRI.COM or contact Individual Sales.

Finally, in September, 2006 Blue Cross developed a version of Choices magazine for members of our Direct Pay plans. Historically, Direct Pay members have received a copy of the Commercial version based on their plan (i.e. Direct Blue members received Choices with the Classic insert). This will allow provide us with the ability to address issues specific to the Direct Pay market.

Q. Are detailed proposed plan descriptions available for the four Class DIR products you have described?

A. Yes. Contemporaneous with this rate filing, Blue Cross has filed with the OHIC proposed revisions to the contract forms for each of the four products described above. These proposed forms provide detailed descriptions of the benefits and other terms of the proposed subscriber agreements.

Q. Generally what are the changes being proposed to the plans effective April 1, 2007?

A. First, I should note that since the last Direct Pay filing the Legislature has mandated new or additional benefits or coverages with regard to hearing aids, scalp prosthesis, smoking cessation and dependants to age 25. We will be complying with these mandates and the rate effects are discussed in Mr. John Lynch's Pre-Filed Testimony. In addition, effective April 1, 2007 for both HealthMate Direct 400 and HealthMate Direct 2000 we are proposing to remove the deductible from Ambulance Services to align this service with the Emergency Services benefit.

We will also be implementing a managed pharmacy program on HealthMate Direct 400 and 2000. The Managed Pharmacy Program includes the following components:

- Half-Tab program: With a physician's approval, members who take a one-tablet dosage can obtain their medication in double the strength, take a half-tablet dose, and pay half of the normal copay. This is a voluntary program, only being used on select non-toxic drugs.
- Dose Optimization: With a physician's approval, members who usually take two tablets can get their medication in double the strength and only take one tablet a day. Depending on the cost of the prescription drug this may reduce a member's

copayment. If the physician feels it is necessary for the member to continue to take the two lower dose pills, he or she can submit a prior authorization form to WellPoint, our pharmacy benefits manager. This form will be located on BCBSRI.COM.

- o Over the Counter (OTC) Block: Certain prescription medications that have an over-the-counter equivalent will not be covered in the prescription form.
- o Prior Authorization Program: Designated brand name drugs will require prior authorization from a physician. The prior authorization form will be located on BCBSRI.COM.
- o Medical Only Medications: Specific list of medications that are administered under the direction of a physician, will only be covered as a medical benefit, and can no longer be purchased at a pharmacy.

Q. Are you implementing changes on the HealthMate for HSA 3000 and 5000 products?

A. At this time we are not proposing making any benefit or procedural changes to these products other than to incorporate the new mandated benefits described above, subject to deductibles. They have been on the market for less than one year and Blue Cross believes that they are meeting the needs of the market. We will continue to monitor the market and, if needed, propose benefit changes in the future.

Q. Does Blue Cross provide any medical management programs for the Direct Pay population and are they designed to address affordability principles exposed by the OHIC?

A. As part of Blue Cross' ongoing commitment to address affordability on behalf of our members, we have created a multi departmental team of organizational leaders whose sole purpose is to address the issue of the "affordability" of healthcare. This group has created a number of new programs, many of which will be described later, designed to support that

objective. In addition, as a part of our existing and ongoing efforts, Blue Cross' Medical Management program continues to evolve towards a member centric care continuum. While the goal remains to provide our members access to high quality and appropriate health care, we have implemented a number of programs and processes that support our efforts toward affordability. Medical Management is staffed by clinical (Nurses, Social Workers, Dieticians, and Board Certified Physicians) and non clinical (support) personnel whose work has met national standards for performance excellence set by the American Accreditation HealthCare Commission/URAC and National Committee on Quality Assurance (NCQA).

Our Utilization Management and Medical Policy processes facilitate the use of the least costly, most appropriate setting and use of evidence based medicine, respectively. Chronically ill members are assessed, stratified and actively managed through our Case and Disease Management programs. Our Provider Profiling program also promotes cost effective use of resources. Last, our Pay for Performance programs, including Quality Counts, demonstrate our focus on primary care. Collectively, these health management programs are available to all members, including our Direct Pay members, for whom Blue Cross underwrites their medical risk.

Q. Can you provide a detailed description of these programs, as well as programs being planned for the future?

A. Certainly. **Utilization review** functions ensure claims are paid only for services which are:

- Actually rendered,
- Billed in compliance with applicable subscriber agreements, and
- Medically necessary.

Additionally, these functions ensure that services are rendered in the most cost effective settings available, in keeping with the definition of medical necessity included in the subscriber contract.

The majority of utilization review is prospective or concurrent. This is done onsite at selected facilities and telephonically for others and includes review of services such as inpatient hospitalizations, rehabilitation, skilled nursing facility care, and out of network requests. Registered nurses conduct the review process in order to ensure our members are being efficiently managed throughout the continuum of healthcare. InterQual is a nationally recognized criteria utilized by more than 2,500 hospitals including the Hospital Association of Rhode Island. It is used as a screening tool for the nurses to determine the appropriate level of care for the member and make appropriate referrals to Blue Cross' Medical Director. As a result of the review process, reimbursement to a facility may be reduced or denied. During the review process, in addition to monitoring the length of stay, our nurses proactively identify and coordinate the members discharge needs. In fact, we have a dedicated team of nurses and other support staff that help our hospitals with discharge planning by arranging for post hospital services, including transfers to skilled nursing facilities, and arranging for the delivery of necessary equipment to the home.

In the course of the utilization review process our nurses identify members who would benefit from our case and disease management programs and make timely referrals to these programs, which will be described in further detail below.

Other utilization review activities may also include review of selected programs and the appropriateness of certain medical equipment used in the home. The nurse will review clinical data specific to the member's needs and compare the request to the Blue Cross medical policies as well as the Medicare Guidelines. If the information provided meets the Blue Cross

guidelines, a notice of approval is sent to all parties involved via fax or letter. If the nurse can not approve the request, the case will be referred to a Blue Cross Medical Director which may result in an adverse determination.

All adverse decisions are followed up with written documentation including a specific rationale and reference for the denial in accordance with the State of Rhode Island Rules and Regulations for Utilization Review of HealthCare Services. During the 2005 calendar year, collectively these services realized claims savings of $1.07 per member per month.

Medical Policy:

The Blue Cross medical policy department is responsible for reviewing requests for coverage of new technology, changes in benefits, new mandates, and requests for revision to a current policy. Medical policies help us to determine whether medical services and/or supplies are medically necessary, experimental, investigational, or cosmetic in nature. In addition, all medical policies undergo an annual update. This annual review ensures that any changes to medical criteria are addressed and our policies are up to date with current practice. Policies are developed and/or modified for several reasons. We may receive a request for a new policy or modification to an existing policy from providers. In addition, our Medical Directors meet monthly with our appeals staff to review appeal statistics and reasons for overturned determinations. As part of our ongoing effort to be responsive to member concerns, if we find a consistent pattern of overturned determinations on a particular policy, the policy is reviewed again to be sure it is within current guidelines. Our policy request forms are available via paper or our website. Once a request is reviewed, the same process is followed.

- It is assigned to a staff member who begins the research and drafting process.
- A letter is sent to the requestor advising that we have received the request and we will have a determination within 60 days. Our current departmental turnaround time is 38 days.

- The policy developer researches several sources to obtain the latest information regarding the policy; this includes but is not limited to:
    - Peer-reviewed medical literature, such as The New England Journal of Medicine and the Journal of the American Medical Association.
    - Evidence-based guidelines developed by public health and nationally recognized health organizations such as the National Institutes of Health and the American Heart Association/American College of Cardiology.
    - The Blue Cross and Blue Shield Association Technology Evaluation Center comprised of physicians that are considered national experts in their field.
    - Regulatory agencies, such as the United States Food and Drug Administration agency (FDA).
    - Selected community participating physicians and healthcare professionals who would be affected by the policy and/or serve as members of our Specialty Advisory Committees.
- Our actuarial staff conducts a cost analysis.
- The draft policy is then presented to our Medical Review Committee which consists of representatives from internal areas such as contracting, marketing, legal, customer service. This ensures that that all factors are considered during the drafting and implementation process.
- Once a policy is finalized, a letter is sent to the requestor advising them of the outcome and, if applicable the implementation process begins.

Participating providers are notified in writing of any new or updated policies with 60 days advanced notice. In addition as of July 2005 we began making updated and new medical and reimbursement policies available via the BCBSRI.COM website. We will continue to add

policies to this site in the coming year. In support of transparency in July 2006, we made these policies available on the web before authentication (on BCBSRI.COM go to Plans & Services, Services, Medical Policies). This allows non-participating providers and non-members access to our medical policies as well as our members and participating providers.

In addition to medical policies, the department is also responsible for creating and maintaining reimbursement policies. While these policies have no medical criteria, they do document our claims processing rules for certain services so providers are aware of correct billing procedures. These are also available on the provider web page. Estimated savings from our medical policy process for calendar year 2005 is $1.59 per member per month.

Provider Profiling:

Physician profiling is the process in which individual physicians or groups of physicians are compared to others in their same specialty with regards to total annual claims cost and overall outpatient service utilization. The data reviewed falls into several large categories, including office visit services, diagnostic imaging, laboratory testing, and surgical/procedural services. From each of these categories, the data can be drilled down further to specific services by CPT code. The following is an outline of the process:

- The provider is selected for review through a variety of mechanisms that include:
  - Normal provider profiling process, i.e. higher number of services per patient and/or cost per patient when compared to other physicians in the same specialty.
  - A referral to Blue Cross' Special Investigations Unit by a member, provider, national fraud association, law enforcement or other interested party.
  - Analysis performed by another operational area within Blue Cross that shows potential issues with the provider's delivery of services or billing patterns.

- The provider's data is reviewed by the Medical Director to determine if further review is warranted or if there are legitimate reasons for the aberrancy (subspecialty, unique patient population, etc). The case can be closed if the variance is explained/expected.
- If there is no obvious reason for the higher statistics, a random sample of 15 office records is requested from the provider in the area(s) where the provider most differs from his/her peers.
- Office records reviewed may be screened by a Registered Nurse and findings are summarized for the Medical Director's review. In some cases only a Medical Director may perform the review of the sample records.
- The Medical Director either closes the case based on the documentation in the office records or discusses the issue(s) with the provider.
- The Medical Director discusses the issue(s) with the provider and, based upon their conversation, either closes the case or indicates to the provider our concerns with his/her practice patterns and expresses Blue Cross' expectation for improvement. The Medical Director sends the provider a letter following the meeting documenting the following:
- The improvements Blue Cross would like to see in the provider's practice pattern. The letter also explains that Blue Cross will review the provider's practice pattern in a time period specific to the services in question and in general. For example, situations where a provider is performing high volume unnecessary services in his/her office, it is expected that the provider can improve immediately and that such improvement will be apparent in as little as one to three months of claims. More complex issues may require a longer time period for improvement and claims run out for accuracy of data.

- That the provider will be referred to the Medical Peer Review Committee (MPRC), which is composed of a number of local physicians from various specialties, if he/she fails to improve in one or more of the targeted areas within the designated timeframes.

Blue Cross conducts a follow-up review of the provider's data within the time period specified in the letter to the provider. If improvements have been made a letter is sent to the provider noting the improvement. If the requested improvements have not been made, the case goes back to the MPRC for review and their opinion on the next steps.

When providers improve their efficiency and reduce the variability in their practice, unnecessary expenditures are avoided and the quality of care may improve. Blue Cross has found this program to have a defined return on investment over the last several years. For 2005, we realized $0.35 per member per month savings from this program.

Q. Please describe what is being done directly with members to help manage their health?

A. Blue Cross' health management programs are developed for all stages of a member's health care continuum: wellness, acute illness, chronic illness and catastrophic illness.

Wellness:

As a health and wellness partner, Blue Cross understands the importance of prevention-oriented activities for maintaining good health. Blue Cross offers a comprehensive suite of health management solutions to help our members live long and healthy lives. Since prevention is the first line of defense against chronic illness and rising healthcare costs, Blue Cross offers individual, provider, and community-based programs designed to help all members from newborns to seniors reduce their risk of illness.

Q. Please provide an overview of some of these programs.

A.. With the exception of the Little Steps® Prenatal Program, Blue Cross members (including Direct Pay) are automatically enrolled in these programs. In the following summaries, the numbers referenced are reflective of January through September 2006:

Little Steps Prenatal (2,000 enrolled)

This mail-based program helps take some of the guesswork out of prenatal care. After contacting Blue Cross to enroll, participants have the opportunity to receive one free pregnancy care book, a 20% discount on baby safety tools, and educational material for prenatal and newborn care. The program also focuses on the importance of recognizing and dealing with postpartum depression.

Little Steps Newborn (8,000 enrolled)

The Newborn program waives copayments, if applicable, for well-baby visits during the first 15 months of life. Parents also receive a 20% discount on baby safety tools, and an option to receive a free book on newborn care. All eligible members are automatically enrolled in this program after the child is added to the parents' insurance.

Little Steps Toddler (6,500 members)

Designed for children 12 months of age, the Toddler program automatically sends parents a newsletter filled with educational materials including information on childhood immunizations and lead poisoning prevention. This program also includes a newsletter with developmental information, and an option card to receive a free book on toddler topics.

Women's Health (119,000 interventions)

As women have unique health concerns, Blue Cross provides them with a comprehensive guide that delineates appropriate health screenings for their age and answers common health questions women of all ages may have about screenings and tests. This guide is sent to members who have been non-compliant for one or more health screenings. These

members will also receive telephonic reminders to schedule appropriate screenings with their healthcare provider.

Personal Health Assessment (PHA)

This completely confidential questionnaire is available to all members on BCBSRI.COM, including Direct Pay members. The PHA helps members learn more about their personal health, the lifestyle choices they make that impact their health, and their personal attitudes about health and work. Members are asked a series of questions about their health risks, medical conditions, life satisfaction, and work and lifestyle habits. Upon completion, each member immediately receives a customized Personal Health Profile that includes comprehensive, personalized information outlining his or her individual health risk and practical suggestions to help him or her lead a healthier life.

Online Health Improvement Programs

Any Direct Pay member interested in building a healthier lifestyle can take advantage of the online health improvement programs on BCBSRI.COM. These self-directed programs offer tailored information about five key wellness topics: back care, nutrition, stress management, weight management, and smoking cessation. Participants choose which topic they would like to focus on, and then complete a personalized questionnaire assessing their current health status and individual needs. Following the assessment, participants receive a tailored wellness plan along with customized web-based newsletters to help them stay on track.

Preventive Guidelines/Healthy Reminders (132,000 adolescents / 78,000 adult reminders)

We offer our members preventive care guidelines for adults and children. These easy-to-read charts list recommended immunizations, screenings, exams, and health counseling at

suggested ages across the life span. Recommendations are based on national standards of care and Blue Cross' own practice guidelines for providers.

Our preventive programs address the following areas:

Childhood immunizations	Pap tests
Teen immunizations	Mammography
Adult immunizations	Chlamydia

Adult & Child Preventive Health Charts

Choices Magazine (issued to all subscribers)

Blue Cross' award-winning magazine is designed to help members make the best healthcare decisions possible. Improving and maintaining member health has so much to do with the lifestyle choices members make: what they eat...whether they exercise...and whether or not they get regular checkups. To make healthcare choices that will keep members healthy and help to keep healthcare costs down, members need information. Choices provides that information.

Programs in the Community

All too often, the amount of physical activity children receive during a school day is less than optimal for developing bodies and minds. As health and wellness advocates, we realize that helping children be more active will help them stay healthy and have more energy for learning. To assist Rhode Islander teachers and parents in improving physical activity levels and reducing sedentary lifestyles, Blue Cross offers the following free programs to all Rhode Island schools.

Feelin' Good® Mileage Club

This teacher-lead walking program helps to boost the activity level of students grades K-Five. Regular walking activity is tracked by teachers and recorded in the classroom.

Participating students are rewarded with colorful tokens for every five miles of walking. The objectives of the program are to create awareness of the importance and benefits of regular physical activity for children and to teach children a fun and easy way to incorporate physical activity into their lifestyles.

Move, Groove & Improve

This six-week program helps to increase the activity level of children ages six to 13. Participants complete daily activity logs and a program survey to become eligible for prizes at the end of the six-week period. This program was developed by Blue Cross in partnership with Kids First RI and the Rhode Island Department of Health. Move, Groove & Improve is available online through BCBSRI.COM. The objectives of the program are to create awareness of the importance and benefits of regular physical activity for children and help participants build a habit of regular physical activity that can continue throughout their lives.

Community Wellness (10,500 encounters)

Blue Cross is dedicated to improving the health of all Rhode Islanders. Community events such as Walk Rhode Island and the Blue Cross Health & Wellness Van offer screenings, flu shot clinics, physical fitness classes and events, health education, and lectures open to anyone in the Rhode Island community. The community and Wellness Van schedule is available on BCBSRI.COM under the "In the Community" section.

Walk Rhode Island (1,400 participants)

Since 2000, Blue Cross has sponsored Walk Rhode Island. With the goal of improving the health of Rhode Islanders, this family-focused walking event is open to anyone. Traditionally offering a 2-, 5-, and 10-mile route, it is the only non-competitive, non-fundraising walk of its kind in the State that's perfect for people of all ages and fitness levels.

Q. What has Blue Cross done to address acute and chronic illnesses?

A. In addition to the utilization review functions, our clinical staff outreach to members that may be undergoing an elective or scheduled surgical procedure or have experienced a hospitalization. These outbound calls help us to identify any gaps or barriers to post hospital care. We can then work with the attending physician to obtain services necessary to ensure post hospital needs are met, and prevent complications. In the following summaries, the numbers referenced are reflective of January through September 2006.

- *Total Knee and Total Hip Program (169 contacts)* – A telephonic outreach program that provides counseling to members preparing for this surgery, including a safety assessment of the home to support a safe recovery. The nurse follows the member through the recovery course.
- *Post Discharge Calls (3,300 contacts)* – Calls are made to members following discharge from an acute inpatient facility to reassess the member's needs and to ensure the discharge plan was implemented effectively.
- *Patient Advocates (1,400 visits)* – Nurses conduct face-to-face visits to members who are hospitalized at two in-state hospitals to assess their needs and provide information on Blue Cross' programs offerings.

Chronic Illness/Disease Management:

Disease Management (DM) Programs are developed based on claims utilization and cost drivers for inpatient and outpatient services and the likelihood that interventions can reduce further costs. These are tailored toward managing the challenges of living with a chronic condition while achieving personal best health.

Blue Cross has developed Asthma, Congestive Heart Failure, Coronary Artery Disease, Diabetes, COPD (Emphysema), and Smoking Cessation in response to these analyses. Effective

DM reduces complications and acute exacerbations of chronic disease while saving dollars by improving health.

Members are systematically identified through a predictive model and stratified into three levels: low, moderate, and high risk for future high costs and morbidity. Each level of stratification receives interventions appropriate for the stratification level.

- Low risk members with one of the chronic conditions receive educational and awareness materials to promote healthy lifestyle choices, nutrition, exercise, and medication compliance. Approximately 90% of our members fall into this category.
- Moderate risk members with one of the chronic conditions receive telephonic outreach calls to participate in a member centric educational and self-management program with a nurse or dietician. The program length is determined by the goals established and the member progress toward the goals. Approximately 3% of members fall into this category.
- High risk members with one of the chronic conditions receive telephonic outreach calls from nurses, dieticians, and/or social workers to participate in a case management program. The program length is determined by the goals established and the member progress toward the goals. Approximately 7% of members fall into this category.

Asthma Program (21,000 interventions)

Our Asthma Program is designed to help members better manage their disease and improve their quality of life. Members are offered education tools and resources through direct mail, newsletter articles, and the Blue Cross website.

Our Asthma Program offers:

- Age-specific asthma tool kits containing self management tools and educational resources.
- Free asthma class taught by certified asthma educator.

- Quarterly provider notification of patient prescription pattern.
- Case Management Services (for those who qualify).

Coronary Artery Disease/High Cholesterol Program (15,800 interventions)

This program is designed to help members, in coordination with their healthcare providers, take control of their cholesterol and coronary artery disease.

Those in case management or telephonic health coaching have access to the following resources:

- Informational materials on the basics of heart disease, nutrition, physical activity and stress, and a weekly pill organizer to help with medication compliance
- Registered nurse care managers who teach participants about the basic of heart disease, medications, nutrition, exercise, and stress, in coordination with their healthcare provider
- Registered dietitians who can provide individual telephonic nutrition counseling
- For those who need extra help coordinating their care, our certified nurse and social work case managers work with the patient and healthcare provider.

Those in the mail program receive a series of mailings that includes:

- Educational materials about the basics of coronary artery disease, high blood pressure, high cholesterol, nutrition, stress, and exercise
- Recipes
- A medication tracker to increase medication compliance

In addition, all participants are eligible for our smoking cessation programs.

Diabetes Program (23,000 interventions)

Our Diabetes Program is designed to enhance and reinforce good self management practices begun in the office or hospital setting.

Multiple resources provide key elements for maintaining a healthy lifestyle. These resources include:

- Information about diabetes self-care, smoking cessation, and healthy living. Community glucose meter training and trade-in programs are held throughout Rhode Island
- Reminders for important diabetes-related exams and tests
- Diabetes classes – offered throughout the state in the daytime and evening (covered benefit with co-pay), and are taught by teams of Rhode Island Certified Diabetes Outpatients Educators (CDOEs), which consist of dietitians, nurses and pharmacists
- Individual consultation and education with CDOEs (covered benefit, co-pays or coinsurance may apply)

For those who need extra help coordinating their care, our certified nurse and social work case managers will work with the patient and physician/provider.

Heart Failure Program (4,200 interventions)

This program is designed to help members, in coordination with their healthcare providers, take control of their congestive heart failure and improve their quality of life. The program interventions include case management, telephonic health coaching, and a mail program. As stated above, depending on the severity of their illness, members are eligible for a specific intervention. All participants are eligible for our smoking cessation programs.

Members in case management or telephonic health coaching have access to the following resources:

- A self-care handbook and teaching video, a digital scale, and a weekly pill organizer to help with medication compliance

- Registered nurse care managers who teach participants about the basic of heart failure, medications, nutrition and how to monitor weight and symptoms, in coordination with their healthcare provider
- Registered dietitians who provide individual telephonic nutrition counseling
- For those who need extra help coordinating their care, our certified nurse and social work case managers work with the patient and healthcare provider.

Members in the mail program receive a series of mailings that includes:

- Educational materials about the basics of heart failure, high blood pressure, high cholesterol, stress, exercise, and the importance of daily weights and a low salt diet
- Healthy Recipes
- Behavior change monitoring tools such as a medication tracker, and daily weight log sheet.

Depression Program (3,100 interventions)

The specific goal of the Depression Outpatient Management Program is to promote education of members to effectively and adequately manage their symptoms and maximize functional capacity. Achieving this goal depends on promoting patient-practitioner partnerships that will foster patients' ability to manage their disease. To this end, the Blue Cross Depression Management program provides:

- Case management screening and referrals, recognition of potential co-morbidities such as cardiac events or Diabetes and Post-Partum
- Depression information for new mothers
- Provider toolkits which provide screening and referral options for the office visit
- Depression medication compliance notices to providers as well as reminders to members of the importance of adhering to medication management

- Web-based interventions including a provider locator and depression self-screening tools
- Timely mailings to members targeted at instances when depression occurs most frequently

In addition, Blue Cross offers a Telephonic SmokeFree Program that is designed to help members who smoke and who have a chronic condition (e.g. asthma, diabetes, heart disease, COPD) to quit smoking. Members can enter the program by a self referral, referral from a physician, or referral from the disease or case management program. Blue Cross promotes smoking cessation as an educational component within all of its chronic condition management materials.

- Members are screened by the Blue Cross Disease Management and Case Management staff and referred to the Telephonic SmokeFree Program if appropriate.
- A tobacco treatment specialist then administers an individual treatment program consisting of between seven to ten individual sessions of 20 to 30 minutes long. The member receives information about smoking cessation and an individualized plan to quit smoking.
- If pharmacotherapy is indicated, the tobacco treatment specialist may contact the member's primary care physician (if the member approves).
- The telephonic counselor follows up with the member at least 6 and 12 months post quit date for additional support and counseling if necessary.

Blue Cross also conducts community outreach activities to engage members in self management. Community outreach activities include such events as Asthma Classes and a Glucose Meter Exchange Program.

2005 estimated savings for our Disease Management programs were $3.27 per member per month.

Q. Does Blue Cross have a Case Management program and could you please describe the program?

A. Yes.

Catastrophic/ Complex Case Management Program (2,750 members enrolled):

Case management is a collaborative process of working with members who have complex or catastrophic events with the goals of optimizing health, enhancing quality of life and promoting cost effective care. Members are referred from several sources including providers, employers, members, utilization review nurses, claims data as well as a predictive modeling tool. Individualized plans are developed with input from caregivers and the members' treating physicians. Case management manages "alternative benefits." In selected cases where both Blue Cross and the member will benefit, we can coordinate health care arrangements outside the subscriber contract. This is done to cover a particular service when the clinical situation suggests the service would provide the most cost effective means of treatment.

Program Summary

- Outreach calls are made to members in order to assess their needs and determine if they would like to participate in our program. If a member agrees a detailed health assessment is performed which takes approximately 30-45 minutes. At this time health related goals are formed with the input from the member. An introduction packet which includes a letter, brochure, consent form and appropriate educational materials are sent to the member.
- The next step is to contact the member's provider to gain additional input regarding health goals and education or resources which would be beneficial to the member. A fax which includes a medication list and a summary of the areas we will be working on with the member is sent prior to attempting phone contact with the physician. We reimburse physicians $50 for the telephonic consult in order to elicit his/her input.

- Telephonic education and coaching continues in order to move members toward completion of their health goals. At times goals need to be modified. Discharge from the program takes place when the member has completed their goals. Average length of stay in the program is 4-6 months. At the time of completion of the program a discharge letter is sent to the member. This letter includes the name and phone number of their case manager in case there are any questions or if they need to contact her again in the future. Ten days later a satisfaction survey is sent.

Our 2005 Case Management Satisfaction Survey results show 97% of the respondents believed they had a "good to excellent" experience, and 94% believe that the education they received helped to improve their health habits. For calendar 2005, we realized $0.14 per member per month in savings for these members.

Through October 2006, we have over touched over 50,000 members through one or more of the acute, chronic and catastrophic illness programs described above.

Q. Are all of the programs you described above available to Direct Pay members?

A. Yes.

Q. Please describe what Blue Cross has done to respond to the principles enunciated by the OHIC regarding enhancing primary care.

A. Of note Blue Cross has taken a very active role on the steering committee of the Primary Care Stakeholders group, a group created by the OHIC which is designed to create new programs that change the healthcare delivery system to better support primary care. The two key activities of that group thus far are listed below:

1.) Improving After-Hours Access to Primary Care

This year long pilot program is designed to create incentives for infrastructure development in the primary care office that supports patient centered primary care. This pilot

will provide incentive payments to selected primary care offices that expand after-hours access to appointments for both routine preventive care and acute illness care. In total, pilot practices will be primary care providers to a minimum of 20,000 patients.

Blue Cross will work with other insurers (United Health Care, NHP, Medicaid) and purchasers to provide an incentive payment to selected primary care physician (PCP) groups to provide scheduled evening hours.

There will be three outcome measures of this pilot:

Measure 1: Patient Satisfaction with Appointment Availability: baseline at entry into pilot, and after one year. Practices will be responsible for administering survey, which will be provided to them by stakeholders.

Measure 2: After-Hours Utilization: This measure will track the number and type of visits seen after hours. Practices will be responsible for tracking the number of visits after hours, and the diagnostic codes used for the visits.

Measure 3: Emergency Department (ED) Utilization: All pilot practices will be grouped together for this analysis. Patients will be linked to pilot practices using the methodology described below. Plans will measure the ED utilization rate for Ambulatory Sensitive Conditions in the 6 months prior to the pilot start, and during the last 6 months of the pilot.

Pilot practices will receive 50% of the total incentive payment for participating. They will receive this in four equally divided quarterly payouts.

In addition, practices are eligible to receive an additional 50% of the incentive payment for meeting utilization benchmarks. A stakeholder sub-group (the Pilot Fund Board) would adjudicate whether or not benchmarks have been met.

Total dollars available to practices (participation incentive plus utilization incentive) will be $50,000 per practice per year. Ten practices will be in the initial pilot, for a total pilot cost of

$500,000 and each involved insurer will be contributing their pro rata share (based on membership) of that total.

Once approved, the program should begin in the second quarter of 2007.

In addition to the above program, in 2006 Blue Cross responded to the concerns of the primary care community regarding payment for after-hours care by increasing our reimbursement for the after-hours code 99050. Other payers have NOT been willing to follow suit. It is our belief that strong support of after-hours access will lead to reductions in inappropriate and expensive emergency department utilization.

2.) Improving Chronic Illness Care

The goal of this project is to align chronic care improvement goals and financial incentives for the delivery of high quality chronic illness care. This will be accomplished through primary care practice redesign to incorporate the elements of the "Advanced Medical Home/Chronic Care Model" of care. These elements include a host of activities that are rarely seen in the typical practice today, such as: better use of non-physician team members, integration of behavioral health into the primary care practice, enhancements to information systems, links to effective community resources, modern self-management support, group visits, "brown bag" medication review, electronic "virtual" visits, improved care coordination across the various settings of care, etc.

Our intent is to align our pilot project with that of the statewide stakeholders group. We expect to have 35 – 50 PCPs involved in the program over a two-year period. Although the details are yet to be finalized, we anticipate payment on a capitated basis, based on number of members with one or more of the specified diseases. Measures of success of the program will include improved patient satisfaction, improved provider satisfaction, reduced inpatient/emergency room utilization, and improved outcomes.

Q. What is Blue Cross doing in the area of increasing the usage of health information technology?

Health Information Technology:

Blue Cross remains committed to supporting the adoption and implementation of fully functional ambulatory electronic health records (EHR) into physician practices in Rhode Island. Many national studies over the last several years support the concept that widespread use of EHRs lead to improvements in quality of care and patient safety while at the same time reducing the overall cost of care.

a.) *Quality Counts* – This is our Pay For Performance program which is designed to incentivize PCPs to purchase, implement, and utilize EHRs in their practices. We now have a total of 40 PCPs using EHRs as a result of this program. We expect to have another 60 physicians involved in the program by the end of 2007.

b.) Blue Cross has contracted with two large primary care groups in Rhode Island that include incentives to implement EHRs into their practices. By the end of 2006, we anticipate another 120 primary care providers utilizing fully functional EHRs as a result of these contracts.

c.) *Electronic Health Records of RI (EHRRI)* – Blue Cross contributed $300,000 for infrastructure funding to this organization back in 2005, and will be contributing additional dollars by year end 2006 to assist more physicians of all specialties in the purchase of an EHR.

d.) *RI Quality Institute (RIQI)* – This organization, along with the Rhode Island Department of Health, has taken the lead in the development of the statewide Health Information Exchange. We are very much involved with the activities of RIQI. Our Chief Executive Officer, Mr. James Purcell, is a major participant on their Board of Directors, and we

support this group's activities financially with the largest annual contribution of any stakeholder.

Q. Has Blue Cross recently been involved in any pay for performance contracting?

A. Yes.

Pay for Performance (P4P) Contracting

Blue Cross has been involved in P4P contracting with a number of PCP groups over the last few years. These programs involve creating contracts that incentivize doctors to provide high quality, cost effective care, which is measurable. This activity has expanded over the last year, with more dollars at stake and more physicians involved in our programs. Examples of P4P measures include, but are not limited to:

1. discussions with members regarding end of life care/advance directives;
2. use of generic drug prescribing;
3. frequency of electronic prescribing;
4. childhood immunization scores; and
5. use of electronic disease registries to track patients with various chronic diseases.

Q. Do the programs you have described which enhance cost-effective primary care and expand health information technology directly benefit the Direct Pay population?

A. Yes. These programs benefit all subscribers, including Direct Pay.

Q. Please describe the current and future affordability initiatives Blue Cross has or will be undertaking regarding provider contract services.

A. **Hospital And Physician Reimbursement Strategy**

Physician and Provider Fees

Blue Cross anticipates making modifications to its physician fee schedule in the second quarter of 2007. In April of 2006, Blue Cross increased its physician fee floors to 105% of the

2005 Rhode Island Medicare Fee Schedule for most services and a floor of 109% of the same schedule for selected office based evaluation and management codes and mammography codes. .In an effort to maintain market competitive physician fees and address affordability, Blue Cross does not anticipate an aggregate physician fee increase in 2007.

Reduce the Rate of Increase of Hospital Reimbursement

The hospital contracts that are due for renewal in 2008 and 2009 will be closely evaluated, and an aggregate lower rate of increase will be negotiated. Blue Cross will continue to negotiate the best discounts reasonably possible from hospital charges. Keep in mind our Direct Pay subscribers enjoy the benefits of our negotiated discounts when they pay for hospital and physician services falling within their deductible responsibility.

Moreover, Blue Cross through the Blue Cross Blue Shield Association is able to realize savings through negotiated discounts from hospital charges nationwide. The current savings associated with the current discounts for this out-of-state hospital program amount to $200,000,000 on an annual basis corporate-wide. Direct Pay subscribers also directly benefit from these arrangements.

Promote Blues Center of Distinction (COD)

The goal of this program is to promote the establishment of centers of distinction (COD) within Rhode Island to reduce the migration of members to institutions located outside of the State.

As a result of this program, there will be a reduction in post-surgical complications at hospitals designated as CODs. Structure, process and outcomes are measured and weighed to earn the designated distinction. While we have found no hard data to date which identifies specific savings, it is our understanding that these savings do exist. If qualification for the

distinction is based on quality, it is expected that better outcomes with fewer post-surgical complications will save money.

RADIOLOGY

Background Information:

Currently, in the United States we spend more than $200 billion annually on high-tech health treatment and services. The spending accounts for nearly one-sixth of our nation's total health care costs. It has been recognized nationally and locally, that radiology is a top health care cost driver. Increasingly, plans across the country are taking steps to manage these costs. Blue Cross has looked at the data and has made the decision to implement several radiology initiatives to moderate this trend to acceptable levels. Over the course of the next year, Blue Cross will implement a privileging program to ensure better quality of radiological services, implement a recommended pre-authorization program to ensure appropriate utilization (services will be reviewed for medical necessity), enact new policies to curb the waste of dollars in the system and appropriately align reimbursements for radiological services.

A summary of key facts follows:

- The cost of Magnetic Resonance Imaging (MRI) and Computerized Axial Tomography (CT) is rising three times faster than any other physician services.
- The utilization increases of High End Radiology from 2004 – 2005 for the Blue Cross Commercial and Medicare products are as follows:
  - Commercial CT = 7.2%, MRI = 5.8%
  - Medicare CT = 5.5%, MRI = 15.2%
  - In Rhode Island, CT and MRI represent roughly 90% of all the high-end radiological services performed.

- The area of greatest expansion is the number of non-radiologist providers filing for high end radiology services. This volume increased by 22% in 2005. The network of Radiologists as a specialty had a 1% decrease in 2005.

RADIOLOGY INITIATIVES

Provider Privileging Program

The goal of this program is to ensure that providers rendering and billing for radiological services have adequate equipment and qualified staff that meets well established national standards for their equipment as well as their technical and professional expertise. Parameters will be established that outline necessary steps for reimbursement for testing and reading various radiological tests.

Through the elimination of sub-standard radiological machines from the Blue Cross network; the establishment of credentialing criteria for the testing and reading of radiological procedures; quality will improve resulting in fewer incidences of duplicate testing.

Prior Authorization Program

The prior authorization program for radiology will be implemented by January 1, 2008. Under this program, prior authorization will be recommended for radiology services. If prior authorization is not obtained, the services will be reviewed for medical necessity prior to payment of the claim. The purpose of the radiology prior authorization program is to monitor and control the appropriate utilization of high-cost tests performed by all participating radiology providers. Year one total savings based on Vendor RFP responses are estimated to be roughly $6 million.

Reduce Standard Radiology Fee Schedule

A reduction in standard fees for high-end radiology tests will result in a corporate wide annual savings of $1.5 million. The prior authorization program, which will be implemented

January 1, 2008, is intended in part to prevent inappropriate utilization as a result of decreased reimbursements.

Implement Medicare Multiple Radiology Procedure Policy

Blue Cross is underway to adopt policies similar to those implemented by the Centers for Medicare and Medicaid Services (CMS) related to multiple procedures for one single diagnosis. This policy results in a reduction of reimbursements for follow-up or repetitive testing. In August of 2006 the Blue Cross policy adjusted reimbursements to 25% less than standard reimbursement rates for procedures subsequent to an initial assessment. On January 1, 2007 the percentage will increase to 50%.

PHARMACY

Expand the Profiling Process for Pharmacy Programs

As part of an ongoing program, Blue Cross Medical Directors provide educational feedback to physicians based upon periodic analysis of key practice indicators. The reason for expanding the program to include relevant prescribing information is to ensure that doctors are utilizing appropriate and cost effective medication therapies.

Pharmacists accompany Blue Cross medical directors on educational visits to specific physicians. Previously, none of the visits had a pharmacy component. The expansion effort targets as least ten percent of the physicians currently visited by Blue Cross medical directors to also be visited by a pharmacist. The pharmacist discusses the results of the physicians' pharmacy profiling reports. Blue Cross pharmacists maintain baseline data on the physicians that the pharmacists will be visiting. The objective is that the physicians visited by a pharmacist will demonstrate a marked improvement in their prescribing patterns, i.e., prescribing the most appropriate, cost effective medication therapy. The pharmacists will continue to review prescribing data subsequent to the visit to the physician to determine whether their prescribing

patterns have demonstrated improvement. Follow-up feedback to the doctors will be provided as needed. When physicians follow best practices with respect to prescribing, favorable outcomes should be achieved in an optimal timeframe.

Pharmacists continue to review provider reports which identify patterns of high cost prescriptions, an unusual volume of particular medications, and/or prescribing activity which reveals inappropriate use/abuse. Specific physicians have been visited by the pharmacists with the objective of educating them and ultimately reducing inappropriate expenditures on drugs.

Promote the Member Generic Voucher Program

Previously, Blue Cross had a generic voucher program which targeted members who were filling prescriptions for brand name drugs that had a generic equivalent available. The member received a letter advising him/her that there was a less expensive generic equivalent available. The member also received a coupon or voucher which allowed him/her to obtain a one month's supply of the generic at no cost. The process included tracking to determine if those members who took advantage of the voucher continued to utilize the generic medication. This program was very effective and has been re-instituted with Blue Cross' new pharmacy benefit manager. In October of 2006, we began generating letters to targeted members to encourage increased generic utilization and reduce drug expense.

Expand the MedVantx Pilot Program

Blue Cross has partnered with a company called MedVantx to install ATM-like machines known as Sample Centers in physicians' offices across the State. The Sample Center facilitates dispensing of a free 30-day sample of generic medications. Participating physicians receive the Sample Center in their offices at no cost. Blue Cross pays an administrative fee to MedVantx and also pays for the cost of the claim. Currently, there are 28 sites installed within 93 providers having access to generic samples. While Blue Cross continues to roll out the

MedVantx Program to interested participating physicians, there will also be an evaluation of key measures associated with the value of this program to ensure that the primary objectives are being met.

The MedVantx Program increases the dispensing of generic drugs and decreases the utilization of brand name medication leading to a reduction in the overall drug expenditures and a reduction in member's out-of-pocket expenses.

Promote the Use of First Generation Antibiotics

This initiative is designed to implement a clinically based education program focused on providers to increase awareness of appropriate use of first generation antibiotics. Blue Cross will establish a retrospective review program which evaluates the prescribing of antibiotics and whether or not specific physicians could improve their prescribing practices in this regard. This initiative will be incorporated into the comprehensive pharmacy profiling process which will seek to educate physicians by comparing their prescribing patterns to that of their peers and to other relevant benchmarks. Continued inappropriate prescribing may lead to financial disincentives for the physician.

This clinically based education program will "remind" doctors to prescribe antibiotics appropriately, using first generation medications before moving directly to more costly antibiotics.

Recommend a Change to the Rhode Island Generic Prescribing Law to Reflect Massachusetts Generic Prescribing Law

This legislative effort would request that the Rhode Island General Laws regarding pharmacy be amended to restrict the dispensing of brand name drugs with available generic equivalents only upon written authorization of the physician. The patient directed choice of a brand drug would be prohibited. The Rhode Island General Assembly rejected the proposed bill during the 2006 session. Blue Cross will re-introduce the bill in 2007.

Savings would be generated by increasing utilization of generic drugs versus brand drugs. Members would have lower out of pocket expenses. A 1% increase in generic utilization is equivalent to a savings of approximately $2 million corporate-wide.

Over the Counter (OTC) Option

The OTC Options Program is designed to communicate to our HealthMate Coast-to-Coast Direct members that OTC medications offer a safe, effective, and lower-cost alternative to many brand-name drugs. Members eligible for the program will be identified based on past pharmacy claims for brand name prescription allergy medications. OTC loratadine (Claritin) is generally lower cost than other drugs used to treat allergies such as Allegra, Zyrtec, Clarinex, or Singulair. For example, the average cost of loratadine is $6 versus the branded drug cost of $80 per month. If a HealthMate Coast to Coast Direct member were to fill a prescription for Clarinex their copayment would be 50% or $40. Participants of this program will be able to receive the OTC medication at no charge for a period of 12 months. A letter will be sent to members inviting them to voluntarily participate in the program.

Q. Are the corporate-wide savings you alluded to above for affordability initiatives regarding provider contract services relevant to the Direct Pay class?

A. Yes. All of the programs are applicable to Direct Pay and should benefit the affordability of Direct Pay rates.

Q. What is Blue Cross doing in the fraud and abuse area to address affordability?

A. Blue Cross recognizes that fraud is a growing problem in today's healthcare system. The National Healthcare Anti-Fraud Association estimates that between 3% and 5% of healthcare expenditures were lost to fraud in 2003. At Blue Cross the anti-fraud activities are the responsibility of the Special Investigations Unit (SIU) within the Legal Services division.

The goal of the SIU is to detect, correct and prevent fraud, waste and abuse for all lines of business, including Direct Pay. Corporate-wide over 125 potential fraud cases were opened and investigated in 2005. The cases were referred from many sources, internally from Customer Service, calls to the Fraud Hot Line, the provider profiling program and referrals from management. Externally we have received referrals from the Rhode Island Attorney General's Office, the U.S. Office of Inspector General, the Blue Cross and Blue Shield Association, the National Healthcare Anti-fraud Association, Blue Cross & Blue Shield of Massachusetts and the Massachusetts Attorney General's office. We are also installing new anti-fraud software to assist in the detection of potentially fraudulent and abusive billing practices. The software, produced by McKesson Health Solutions, identifies aberrant billing patterns through the use of proprietary algorithms that access the claims system. Installation of the new system is expected to be completed by the end of 2006 and will be operational in the first quarter of 2007.

The SIU investigates cases involving members and providers, including hospitals, physicians, pharmacies, and durable medical equipment suppliers. The types of cases involving members that were reviewed included members enrolling relatives that were not immediate family, members altering receipts from non-participating providers in order to receive more money, members using stolen prescription pads to obtain drugs and then selling them, identity theft and using their individual membership to obtain prescriptions for family members and doctor shopping. We also looked at cases involving providers that bill for services they didn't render, upcoding services to obtain higher reimbursement, unbundling of services, billing members for non-covered services, patient swapping and unlicensed providers billing our members.

In some instances a referral to law enforcement is necessary. In the past year we have made referrals to U.S. Attorney's office, the Office of Inspector General, the R.I. Attorney General's office of Medicaid Fraud Control Unit and the U.S. Drug Enforcement Agency.

While the SIU makes financial recoveries whenever possible, the goal of the unit is to prevent payment for fraudulent services from being made in the first place. It is much better to prevent funds from being paid out than it is to attempt to recover it later. It is difficult to project savings from year to year as the types and magnitude of the cases differ annually. Any recoveries and any funds that are prevented from being reimbursed obviously contribute to the affordability effort. We have estimated that with the implementation of the new software, our savings corporate-wide due to anti-fraud efforts will minimally be $600,000 per year.

Q. Will all of the other affordability initiatives you described above result in lower Direct Pay rates or lower increases in rates?

A. Not necessarily. The public needs to understand and appreciate that some of these programs which are designed to enhance affordability in the long-term may actually initially result in increased administrative costs to establish and implement the programs. Moreover, while we believe our affordability initiatives are reasonable expenditures for which we expect some return, how much, if anything, will be saved in claims cannot be quantified. We do not believe it is prudent to build unknown potential savings into rates. We do know, however, with certainty that to the extent affordability initiatives do result in savings that those savings will roll directly into future claims costs we track, thereby directly and favorably impacting rates at the appropriate time.

Q. What is Blue Cross doing to promote a public discussion about healthcare costs and affordability?

A. We are actively working on the development of an affordability communications campaign regarding healthcare costs. The objectives of the campaign are to educate members on the drivers of rising healthcare costs as well as define what "concrete" steps they can take to help mitigate those costs for themselves as well as for the larger healthcare delivery system. This campaign will seek to create awareness among members, providers and general public regarding specific areas of rising costs. We hope to then engage the member/consumer to take action steps (web programs, speak to their physician, etc.) that result in changes in behavior and perspective as it relates to interacting with the healthcare delivery system. We are targeting a first quarter 2007 launch that will include television, print ads, website within BCBSRI.COM, and brochures/info sheets for members.

On September 26, 2006, about 250 people attended our Annual Community Meeting, "Today's Healthcare Costs". This meeting was moderated by our CEO James Purcell and featured the following panel of speakers:

- Karen Ignagni, President and CEO, America's Health Insurance Plans
- Christopher Koller, Rhode Island Health Insurance Commissioner
- Edward Quinlan, President, Hospital Association of Rhode Island
- Kathleen Fitzgerald, M.D., President and CEO, Rhode Island Medical Society
- Laura Adams, President and CEO, Rhode Island Quality Institute

On a quarterly basis Choices magazine has included articles addressing the topic of affordability. Choices is mailed to all subscribers. Choices TV Show also featured the topic of on Affordability during the first quarter of 2006 (Channel 10).

Q. What has Blue Cross done to address the consumer need for cost information?

A. Blue Cross is an active participant in the Professional Provider-Health Plan Work Group, a subcommittee of the Health Insurance Advisory Council. This workgroup was

established to address the state transparency mandate plan to implement specific transparency initiatives. Blue Cross has emphasized its willingness to participate and contribute to these efforts. We have identified concerns and our own guiding principles. The principles are as follows:

- Collaboration between insurers and providers is necessary for transparency initiatives to reach their full potential.
- Quality information should be transparent to the extent that it can be measured reliably.
- Price information should be transparent only to the extent that it does not inadvertently increase costs for consumers. Concern that specific service level price transparency may have the unintended consequence of increasing health care costs.

Q. Does Blue Cross reinsure any of the risks in the Direct Pay programs?

A. Yes. Blue Cross currently underwrites 10% of the claims for solid organ transplant and bone marrow transplant, and has obtained reinsurance from BCS Insurance for the remaining 90%. Blue Cross continually evaluates whether it ought to continue to purchase solid organ and bone marrow transplant reinsurance, or whether it would be a more cost effective but still prudent exposure to fully underwrite this risk.

Q. Are there any recent legislatively mandated changes to benefits in Direct Pay?

A. Yes during the last legislative session, several laws were passed that impacted the Direct Pay benefits. These benefit changes were implemented in compliance with state laws. See the Pre-Filed Testimony of Mr. John Lynch regarding recent legislatively mandated benefit changes.

Q. What is the source for the hospital inpatient and outpatient price projections contained in this filing?

A. Those price projections are provided by Blue Cross' contracting administration division and are consistent with projected price increases for our group business.

Q. Would you please explain the basis of the physician fee increase projections?

A. Yes. These projections are also provided by our contracting administrative division and are consistent with projected price increases for our group business.

Q. Mr. John Lynch, in his Pre-Filed Testimony, has described the values utilized for operating expense for Class DIR. As the policy witness for Blue Cross, can you explain for us the basis of this projection?

A. Yes. A large portion of Class DIR operating expenses is allocated rather than direct. Consequently, in order to project operating expenses on their own merit, independent of increases in health care costs, the provision of operating expenses in this filing is based upon expense budgets for CY2006, CY2007, and CY2008 developed internally by Blue Cross for Class DIR.

Q. I share a copy of Blue Cross Exhibit 6 and ask you to identify this.

A. This is a copy of the Blue Cross & Blue Shield Cost Accounting Manual. This is the manual which is used by Blue Cross as a guide and is promulgated by the Blue Cross and Blue Shield Association. This is used in our allocation of operating expenses to various classes of business, including Class DIR.

Q. I show you Blue Cross Exhibit 7 and ask you to identify this.

A. This constitutes a cost accounting system overview which explains in summary fashion the cost allocation methodology used by Blue Cross with regard to its classes of business including Class DIR.

Q. Can the allocation method for each of the expense items set forth in Blue Cross Exhibits 6 and 7 to your testimony be specified?

A. As a practical matter, no. The cost accounting system overview makes it clear why this is so. In summary, the reason is that there are literally dozens of allocation methodologies for each item. By way of example, salaries are allocated depending upon which cost center that person's salary is allocated through. Some cost centers allocate salaries on the basis of timesheets (recorded time), and others on function (number of claims, contracts, square feet, etc.). There are many methods of allocation. Blue Cross has over $253.3 million of administrative expenses that need to be allocated annually, and over 375 cost centers.

It is also impossible to state for each such item which costs are direct and which costs are indirect, because direct and indirect expense items are passed through cost centers and aggregated. After they are passed through the cost center, the bottom line amount is computed. The only way to determine which expenses are direct and which are indirect is to go back to the original invoices, go through each, and determine whether each was allocated to a cost center (indirect) or whether it was directly allocated. This, for obvious reasons, would have to be corporate-wide, and such an undertaking would be mammoth. For example, for office equipment expenses, every single invoice for the entire corporation for the entire year, all lines of businesses would have to be retrieved, reviewed, studied, and an analysis would have to be made as to how it was allocated.

Q. How are the 2007 and 2008 Class DIR operating expense budget amounts determined as shown on Blue Cross Exhibit 3, Schedule 55?

A. In preparation for this Class DIR filing, we developed estimated budgets for Class DIR calendar years 2006, 2007, and 2008. Attached hereto as Blue Cross Exhibit 8 is a document entitled "Blue Cross & Blue Shield of Rhode Island Direct Pay – Comparison of

CY07 Budget to CY06 Projected Actual by Natural Account." Blue Cross Exhibit 8 compares by natural account (1) 2006 Projected Operating Expenses to (2) the 2007 Operating Expense Budget. The CY06 Budget is based on actual reported expenditures in 2006, with an estimate for the remainder of the year. The CY07 amounts reflect the budget for the calendar year. The third column of Blue Cross Exhibit 8 shows the increase or decrease between CY06 Projected and CY07 Budget. The fourth column shows the percentage increase or decrease. The last column on the right shows the applicable inflation factor applied. This represents a summary of the methodology by natural account used in determining the 2007 changes from 2006.

As stated at the bottom of Blue Cross Exhibit 8, the methodology used to create the 2007 budget was to estimate the Class DIR operating expenses for 2006 by category and then adjust for inflation and certain other factors. Those factors include a 2.4% Direct Pay contract month decrease for volume sensitive departments and items for 2007 over 2006.

For purposes of this filing, the calendar year 2007 budget results in a total budgeted amount for Class DIR of $5,414,705, as reflected in Column 1 of Schedule 55 of Blue Cross Exhibit 3. This in turn was divided by total projected Class DIR contract months for 2007 of 118,992 for a projected total Class DIR operating expense per contract month figure of $45.50 for calendar 2007. See Column 3 of Schedule 55 of Blue Cross Exhibit 3.

For 2008 attached hereto as Blue Cross Exhibit 9 is a document entitled "Blue Cross & Blue Shield of Rhode Island Direct Pay – Comparison of CY08 Budget to CY07 Budget by Natural Account." Exhibit 9 employs the same format as Exhibit 8, except that it compares CY08 to CY07. The CY08 Budget amount of $5,716,624 is divided by the total Class DIR contract months for 2007 of 118,992, for a projected total Class DIR operating expense per contract month figure of $48.04. The methodology involves a projected no change in enrollment for volume sensitive departments and items for 2008 over 2007.

Attached hereto as Blue Cross Exhibit 10 is a detailed narrative breaking down the administrative expenses for the Direct Pay budget.

Q. Is David Fogerty, Assistant Vice President, Financial Planning available to answer any additional questions with regard to cost allocation and budget methodologies that anyone may have?

A. Yes. He is. That is within his department and that is his responsibility. He is also available to answer any questions on the computation of specific allocation of administrative expense items, and operating expense budgeting that I cannot answer.

Q. Did the Blue Cross Board of Directors authorize this filing?

A. Yes. The Blue Cross Board of Directors ("Directors") met on October 5, 2006, at which time this filing was considered and discussed. The Directors' Finance Committee, which has primary oversight of all rate matters, also reviewed and authorized this filing at its meeting held on September 28, 2006.

Q. Based upon your job responsibilities and based upon your discussions with the officers and Directors of Blue Cross, as well as all information to which you have been privy as a result of your duties at Blue Cross, are you familiar with the issues considered by Blue Cross and its Directors with respect to the interest of Blue Cross and with respect to the public interest in requesting the rates which are the subject of this rate proceeding?

A. Yes, I am.

Q. Would you please describe what Blue Cross and its directors considered regarding the interest of the public with respect to the proposed rates?

A. Yes. Blue Cross and its Directors have historically taken the position that Direct Pay should recover not only its claims and administrative expenses, but it should contribute its fair share towards corporate reserves. This over-arching long-term policy remains unchanged.

Q. What is the most recently available contingency reserve figure for Blue Cross?

A. Blue Cross' overall corporate statutory reserve as of September 30, 2006 was $364 million, or 22% of statutory accounting principles (SAP) premium. This is equivalent to 2.6 months of insured premium or 91 days of claims payments.

Q. What is the reserve target for Blue Cross?

A. Blue Cross' reserve target is a range of 25% to 35% of annual insured premium. This target is a result from a review of our reserve requirements conducted by Milliman USA ("Milliman"), our consulting actuaries, in early to mid 2000 (updated in 2003). The purpose of the review was to determine the appropriate level of reserves in order to provide Blue Cross and its subscribers with the financial stability necessary to avoid a financial crisis such as that experienced by Blue Cross in 1996 through 1998 (The third such loss cycle experienced by Blue Cross since 1980). The 1996 through 1998 loss cycle not only endangered the future of Blue Cross as an independent, non profit, locally controlled Blues Plan, but also caused the demise of Harvard Pilgrim Health Care of New England and Tufts in Rhode Island. The Milliman study set our target range for corporate reserves at 25% to 35% of annual insured premium. A second opinion on our reserve requirement was sought from the actuarial consulting firm of Reden and Anders. The results of that study confirmed the validity of the Milliman's reserve range. Recently, pursuant to a legislative directive, the OHIC conducted a study to evaluate the reserve requirements of Rhode Island's domestically located health insurers. The Lewin Group was retained by the OHIC to perform the study. They released a report earlier this year recommending a range 23% to 31% of insured premium for Blue Cross. In our analysis, the Lewin Report validated the necessity of adequate reserves and the reasonableness of our established reserve target.

Note that Blue Cross of Rhode Island was ranked 29th out of 38 Blue Cross Plans nationally in health risk-based capital, as of June 30, 2006.

Q. Are reserves for Class DIR projected to be below the 25% to 35% of annual premium current target range during the rate period for which rates are sought?

A. As of September 2006, Blue Cross Direct Pay had a negative Class DIR reserves balances of ($7.7) million. Assuming the requested rates are implemented as filed it is projected that at the end of the rate year (March 31, 2008), Class DIR will still have a projected negative reserve balance of ($6.3) million.

Q. What is the reserve contribution sought in this Direct Pay rate filing?

A. Blue Cross is seeking a 2% contribution to reserves. This is consistent with our underwritten group business and the currently approved reserve contribution for that class of business.

Q. What is the availability of Class DIR to the public?

A. Blue Cross has been pleased to continue to conduct periodic open enrollment of Class DIR over the years. No legislative mandate was required for this to continue. Blue Cross and the Directors have taken pride in the fact the Direct Pay program has been offered to anyone who wants it and that, because of Blue Cross, there is no one who is "uninsurable" in the State of Rhode Island from an availability perspective. As indicated above, Blue Cross alone insures this segment of Rhode Islanders. United Healthcare and other carriers have no interest in entering this market. Blue Cross has set two goals for itself in Direct Pay: (1) to make coverage "available" to all Rhode Islanders; and (2) to make the coverage as "affordable" as possible—while recognizing that in the long run this is not an issue which Blue Cross alone can resolve. Use of the different pools with a health screening and application process for Pool II assists in attracting younger and healthier subscribers, thereby benefiting all in Direct Pay,

including Pool I subscribers. Pool II became a vehicle which helped slow down the cost spiral that had been experienced by this class. It has helped address problems associated with the health characteristics, age, and relatively high claims expenditures for Class DIR by injecting the potential for better health experience in the future and to rejuvenate that class. By continuing to seek to better align the rates of the pools as described in Mr. Lynch's Pre-Filed Testimony, Blue Cross also believes that Direct Pay will be able to attract more healthy subscribers for the benefit of all Blue Cross subscribers.

Q. In addition to what you have previously testified to, is Blue Cross doing anything else to address affordability of health care coverage for Class DIR?

A. Yes. In 2006 Blue Cross instituted an innovative Direct Pay Premium Assistance Program to help lower income Pool I subscribers and absorb some of the escalating costs of health insurance premiums. Effective April 1, 2007 Blue Cross plans to expand this program to include lower income Pool II subscribers. We also plan to expand the program in additional ways described below. A separate Interim Report to the OHIC discussing our experience to date with the Premium Assistance Program will be submitted under separate cover contemporaneous with this filing.

Q. Is the Premium Assistance Program part of the rates?

A. Blue Cross' legal position is the program is part of the charitable mission and return to the community described below and not part of the Direct Pay rates. The Premium Assistance Program is an added benefit to the program that is not included in the rates charged to Direct Pay subscribers. We believe this question is academic in the context of this filing, and Blue Cross' legal counsel can further explain our position at the hearings if need be.

Q. Please describe the Direct Pay Premium Assistance Program generally.

A. This program is a direct outreach activity, authorized by the Blue Cross Directors to help improve the affordability of healthcare coverage in Rhode Island for eligible subscribers who have acted responsibly by purchasing their own Direct Pay coverage, but (1) are not eligible for either employer or government sponsored or assisted healthcare coverage plans (i.e., employer group coverage (other than a self-employed individual), Medicare, Medicaid, or VA), and (2) have relatively low incomes from which to purchase coverage.

Q. Why is Blue Cross offering the program?

A. This program is a central part of Blue Cross' overall corporate commitment to performing as a successful business enterprise, and then making a "return" from that success to the community. It is one of the ways in which we intend to fulfill our corporate mission to "provide our members with peace of mind and improved health by representing them in their pursuit of affordable high quality healthcare" (from our corporate mission statement). The Premium Assistance Program focuses directly on the issue of the affordability of the company's healthcare coverage for a segment of Rhode Islanders who are taking responsibility for covering their healthcare needs—but who have lower incomes and do not have the benefit of employer or government sponsored or supported plans available to them, yet they face a significant financial burden as they receive no assistance from employers or government in obtaining their health coverage.

Q. Please provide some details regarding the proposed changes to the Direct Pay Premium Assistance Program which will be effective April 1, 2007.

A. The proposed changes include:

- opening the program to members who have the Preferred Rate (Pool II);
- increasing the highest income guideline from 300% to 350% of the Federal Poverty Level (FPL); this means that based on the 2006 FPL, individuals with an

annual income lower than $34,300 are eligible for the program, as are families with an annual household income lower than $58,100 for a family size of 3;

- use of the 2007 FPLs as the income guideline; and
- a 20% increase to the dollar amount of assistance provided to members who qualify for the program.

We estimate that after the program enhancements are implemented, that the percentage of people receiving assistance will increase from 8% of the direct payment population to 18%.

Q. Who would be eligible for assistance?

A. Rhode Island residents who are enrolled or enrolling in one of our Class DIR plans and meeting the following requirements.

- Annual gross household income level below 350 percent of the FPL with the highest level of assistance (Level 1) to those with 200% FPL or below, and a lesser level of assistance (Level 2) for those between 200% and 350% of FPL);
- Eligible recipients may not be eligible for coverage under Medicare, TriCare, or other federal programs nor eligible for coverage under RIte Care or other state programs; and
- They must not be eligible for employer-sponsored group coverage.

Q. How much assistance will be made available to each subscriber?

A. Over the course of the 12-month rating period beginning April 1, 2007, the assistance is expected to provide an estimated $852 for each eligible Direct Pay individual subscriber and $1,608 for each corresponding eligible family subscriber with an income at or below 200% of the FPL. This equates to assistance ranging from 7% to 74% of total premium depending on the product selected.

Additionally, Direct Pay subscribers who have incomes between 200% and 350% of the FPL, premium assistance over the course of the 12-month rating period is an estimated $564 for each eligible individual subscriber and $1,068 for each eligible family subscriber falling into

this between 200% to 350% of FPL category. This equates to assistance ranging from 5% to 49% of total premium depending on the product selected.

Q. What are the federal annual income poverty levels and how does that relate to Direct Pay demographics?

A. The 2007 Federal Poverty Levels are scheduled to be released in February of 2007. Once released, Blue Cross intends to implement the new levels on the income guidelines for April 1, 2007. 2006 Federal Poverty Levels are as follows:

Family Size	100%	200%	300%	350%
1	$9,800	$19,600	$29,400	$34,300
2	$13,200	$26,400	$39,600	$46,200
3	$16,600	$33,200	$49,800	$58,100
4	$20,000	$40,000	$60,000	$70,000

It should be noted approximately 7,500 or 78% of Direct Pay contracts are for individual coverage. With respect to family coverage, the average size family in Direct Pay is three persons.

Q. How much has Blue Cross set aside for the Premium Assistance Program?

A. Last year, Blue Cross set aside a total of $4.5 million as seed money for this program. We expect to use $0.5 million in this rate year (2006) and because of program expansion approximately $1.5 million in rate year 2007. The remaining monies could be drawn down in order to continue payouts under the program during periods when Blue Cross' financial results may not enable a dividend or "return" in the form of additional funding. Blue Cross' goal, however, is to generate sufficiently favorable ongoing financial results so that a portion of the favorable results can continue to be available to fund worthy programs such as the Direct Pay Premium Assistance Program. Specifically, for 2006 Blue Cross will set aside an

additional $4.5 million for the Premium Assistance Program, bringing the total 2 year contribution to $9.0 million.

Q. How long will Blue Cross continue the Direct Pay Premium Assistance Program?

A. The Direct Pay Premium Assistance Program is relatively new to Blue Cross, and to Rhode Island. Blue Cross will continue to study it, and adapt the program as its effectiveness and Blue Cross' means of support warrant. Underpinning the program's ongoing viability is the need for Blue Cross to be able to implement actuarially justified, adequate premium rates – for Direct Pay, as well as all other segments of business. The program will be monitored closely by Blue Cross, and future funding, payment levels, and eligibility will be modified or terminated as appropriate.

Q. Please describe Blue Cross' overall proposed approach to community "Return."

A. The foundation for undertaking a community outreach and "return" effort such as the Direct Pay Premium Assistance Program begins with Blue Cross' corporate mission to "provide our members with peace of mind and improved health by representing them in their pursuit of affordable high quality healthcare." Toward that end, we are committed as a corporation to:

- making ***high quality health insurance*** available to a comprehensive range of consumers
- assisting and supporting ***healthcare initiatives*** for individuals without healthcare insurance
- contributing to the ***improvement*** of medical and prevention services delivered in Rhode Island
- promoting a coherent, integrated, and efficient statewide ***healthcare system***
- ensuring that Blue Cross is ***financially viable*** and maintains the ***resources and stability*** to accomplish our mission

(from our corporate mission statement, emphasis added)

Blue Cross is actively pursuing each of these areas of commitment. We continue to examine our products for market acceptance, cost effectiveness and affordability. For Direct Pay, as an example, we recently created a new generation of products in 2006 – designed to be cost effective and to improve the affordability of the premium rates required.

Q. What are some of Blue Cross' other mission related activities?

A. Blue Cross is committed to working together with key stakeholders to provide healthcare services to the uninsured and address serious systemic issues impacting healthcare in Rhode Island. Our corporate social responsibility strategy includes these major initiatives:

- Blue Cross Community Health Fund—in 2005 Blue Cross took a major step in demonstrating our commitment to the Rhode Island community by establishing the Blue Cross Community Health Fund, a donor advised fund with the Rhode Island Foundation. The Community Health Fund was established as a long term commitment to support non-profit agencies that provide health education and prevention services to the uninsured and underserved populations in our community. Blue Cross endowed the fund with a tax deductible contribution of $1.5M and we make recommendations regarding the distribution of money in the fund to local health related programs and services. We will continue to contribute to the fund as the financial stability of the company allows with a long-term goal of achieving a fund balance sufficient to provide health related charitable giving to neediest in our community on a self sustained basis.
- Over the past three years, the BlueAngel Community Health Grants and other charitable contributions have provided $2,237,000 to the community health centers, and approximately 200 other local agencies servicing the health care needs of Rhode Island's uninsured and under-insured.
- Blue Cross is the largest funding partner of the Rhode Island Quality Institute (RIQI) which is dedicated to improving health care quality by applying sound operational and technological approaches to the system of care statewide.

- In addition to supporting the RIQI, Blue Cross also supports statewide quality improvement efforts through its support of Quality Partners Rhode Island (QPRI). Blue Cross contributes both financially and/or with staff time to projects that are focused on improving quality in areas such as home health, hospital, nursing home and physician office settings.
- Over the past few years Blue Cross also funded the Statewide Health Assessment Planning & Evaluation (SHAPE) study which focused on the demand for and supply of health services for Rhode Islanders. The nursing study in particular provided significant data to support recent efforts to address the nursing shortage in Rhode Island. Overall, SHAPE provided a transparent and inclusive process of objective research and analysis.
- Blue Cross has also been a major financial contributor to Electronic Health Records Rhode Island (EHRRI). We know that electronic health records have the potential to improve the quality of health care delivery and improve efficiency through a reduction in medical error, elimination of duplication, and enhanced collaboration among healthcare providers.
- The Blue Cross partnership with Brown Medical School is currently engaging physicians in the process of improving quality care delivered in an efficient manner by integrating medical claims data with contemporary Evidence Based Best Medical Practice guidelines. This collaboration is specifically designed to contribute to improved health care delivery and promote a coherent, integrated, and efficient statewide health care system.
- Blue Cross initiated the Rhode Island Health Literacy Project (RIHLP), a state-wide coalition of public health, adult education, and medical organizations. Through a collaborative approach, the RIHLP seeks to heighten awareness of health literacy issues so that all Rhode Islanders better communicate and understand health information, treatment options and self-care instructions. Blue Cross provides staff support and other resources to the RIHLP which is presently developing a RIHLP web site as well as programs/tools for: adults with low literacy, physicians/providers in communicating with patients, written material with consumer health messages.

- Through the Community Health & Wellness Van, the company also brings preventive screenings and wellness programs onsite to the community making over 270 visits to local senior centers and non-profit agencies throughout the state. Blue Cross also supports state boards and commissions with experienced professional staff that work collaboratively with community leaders to shape policies and interventions that improve public health.

Q. How do Blue Cross' mission and its finances interact?

A. During the past several years, a crucial focus for the company has been on ensuring our future financial viability. Without sufficient reserves and operating stability, we simply cannot carry out our mission. With initial progress having been made on meeting our reserve target, and reasonable operating stability having been achieved, we are now better positioned to address issues such as affordability more comprehensively, including contributing a portion of our recent operating gains as a "return" to the community. We can only continue to do so, however, if we also continue to be successful financially. Ongoing financial success, therefore, becomes both (1) a measure of our performance as a well run, competitive business enterprise, and (2) the source of our financial means to undertake core elements of our mission to support Rhode Islanders in their pursuit of affordable high quality healthcare.

To pursue our mission as an independent, non-profit health plan in the State, Blue Cross has identified four cornerstones for our operating foundation. They are:

- Attractive, high quality ***products and service***
- Strong ***reserves***
- Ongoing ***operating gains***
- Structured ***"return"*** to the community

Each of these cornerstones is important in its own right. More importantly, however, the four cornerstones must all work together to forge a sound foundation for the company. No one of them can be ignored or sacrificed; and no one of them can be pursued unilaterally without

full regard for the others. An integral part of our mission is to offer high quality health insurance products and service. Since we operate in a market environment, we must continually offer products with competitive designs and features, at appropriate prices, supported by strong customer service. Our filing for Direct Pay exemplifies the importance placed by Blue Cross on maintaining up-to-date, cost effective, and affordable products for our various segments of business. The corporate reserves maintained by Blue Cross enable us to guarantee protection and provide peace of mind to our subscribers. Reserves provide the company with the capitalization that is essential in order to safely assume the risks associated with offering health insurance coverages, as well as funds to re-invest in technology and infrastructure for the future and to enable responses to changing customer or market demands. Ongoing operating gains are achieved by simultaneously meeting customer needs and expectations, charging appropriate but competitive prices, and managing the company effectively, especially with regard to provider contracting and management of care and internal business operations. Successfully achieving all of these outcomes simultaneously is a complex and difficult task, but an essential one. Ongoing operating gains are necessary in order to maintain our reserves (which must grow along with the dollar volume of our business in force), enable investment in the company for the future (e.g., new products, technology), to help ensure the adequate funding and effectiveness of our healthcare systems in Rhode Island, and provide for any "return" to the community that we might make, including outreach efforts to help address affordability.

A structured approach to making "returns" to the community is important to help ensure the effectiveness of the contributions involved, within the context of appropriateness, financial prudence, and sustainability. The contributions we make as a company take many forms – from corporate leadership and participation in broad-based local healthcare initiatives, to local employment, to member healthcare and wellness promotion, to monetary support. All of these

entail the use of resources, and all must be organized and managed in order to be most effective. This is a principal reason why we have structured our proposed Direct Pay Premium Assistance Program as we have. It involves discrete, identified amounts of financial support to help address directly premium rate affordability. It is focused on those subscribers who have lower incomes but who do not have the benefit of support from employer or governmental programs, i.e., those who we believe need assistance with the affordability of their premiums the most. With adequate direct pay rates, and proper financial management of both the program and Blue Cross overall, the Direct Pay Premium Assistance Program should be sustainable over time.

Q. What are other examples of Blue Cross' ongoing "return" to the community?

A. "Return" has taken various forms in the past, some of which have been financial and others which have been in the form of resources and volunteers. Blue Cross has been an integral part of the Rhode Island community since 1939. Our vision is to improve the quality of life of Rhode Islanders by improving their health. As the leading local health insurer, we have a responsibility for the healthcare needs of our members. We also have a responsibility to the community at large, especially to those individuals who are uninsured or financially unable to pay for their healthcare. We fulfill this responsibility in part through our nationally recognized BlueAngel Community Outreach Program, which includes employee volunteerism, charitable giving, grant making, and a host of other community service activities.

Through our BlueAngel Community Outreach Program, the company partners with non-profit agencies and encourages employees to participate in charitable giving and volunteer service. Over the past three years (2003-2005) our BlueAngel Program has provided employee volunteers, as well as employee contributions of time and in-kind service:

- 2,370 employee volunteers
- 9,878 volunteer hours

- $605,906 employee contributions through the United Way and other fundraisers
- $104,321 in-kind services such as printing, office equipment, computers, etc.

In addition, generally 100% of our senior management team is involved as directors or committee members for local non-profit agencies. Currently, 14 members of senior staff provide volunteer service to over 40 local agencies including Crossroads RI, Day One, the Greater Providence YMCA, Boys & Girls Clubs of Providence, and the American Red Cross of Rhode Island.

Our goals are clear and our community contributions must be (1) systematically supportive of and compatible with our corporate mission, (2) commensurate with our financial means, and (3) made in a way that is sustainable over time, to the extent possible. There is much we do not know and have yet to learn, and both the community's needs and the company's circumstances will undoubtedly change over time; so our thinking and actions must necessarily also grow and evolve over time. We have identified and adopted two fundamental enabling principles to help guide in continuing the Premium Assistance Program. These principles are directly related to the goals just enumerated for our community contributions and to the four cornerstones of our operating foundation, as described earlier. The two principles are:

- Ongoing ***financial success*** is a prerequisite to making a "return" to the community
- A ***structured overall approach*** to providing a "return" is necessary to ensure focus, prudence, and sustainability

The first principle is the fundamental fact that "returns" to the community are possible only if the company is both adequately capitalized (i.e., sufficient reserves) and generates ongoing operating gains. Reserve targets must be met and appropriate re-investment made in the company for our future success, before a "return" is prudent. Funding for a

"return" must then actually come out of a portion of ongoing gains – so long as operating stability has been achieved and meaningful progress has been made in moving systematically toward an optimal level of reserves. Such gains enabling a "return" will only be available if premium rates are first sufficient to cover operating costs, identified needs for re-investment, and planned accumulation of reserves. This means, in brief, that actuarially sound rates must be maintained continuously for all segments of business.

The second enabling principle to help guide the Plan in addressing "return" to the community is the need for a systematic, structured overall approach. This is essential to help ensure focus, financial prudence, and sustainability over time. It includes, for example, such components as:

- ***Reserve accumulation plan*** – Establishing and pursuing with discipline a multi-year reserve accumulation plan for the company (part of the business planning process).
- ***Target "return"*** – Identifying the amount to be set aside and earmarked for "return" to the community.
- ***Sustainable approach to expenditures*** – Expending earmarked funds gradually so that company efforts and funding can be sustained over time (even with intervening poor financial years).
- ***Fiduciary responsibility*** – Assuring that Board of Directors' authorization and oversight occur in connection with the earmarking or expenditure of funds for "return," since this is a use of corporate assets for other than normal operating expense purposes.
- ***Expenditure plan and monitoring*** – Maintaining a multi-year plan for expending funds set aside for "return" to the community, consistent with our corporate mission and with financial prudence, and then monitoring its effectiveness closely.

– ***Conforming financial reporting*** – Allocating "return" funds when they are so earmarked, and tracking subsequent grants or other expenditures against such funds.

Q. How does the overall community "return" concept relate to this Direct Pay filing?

A. We believe that expanding the Direct Pay Premium Assistance Program as part of our overall approach of a dividend or "return" to the community, is appropriate and timely.

As discussed earlier, any application of funds earmarked for "return" to the community must be consistent with our corporate mission and must be an identified component of our overall expenditure plan for such funds. Financial prudence would also dictate that such funds be applied in a manner that is manageable vis-à-vis determinability of the amount of funds to be expended in total and sustainability over time. Blue Cross has concluded that continuing and expanding the Direct Pay Premium Assistance Program satisfy these criteria, and is a mission-based, high priority initiative for helping our members in their pursuit of affordable high quality healthcare.

Q. What are the expectations for the future?

A. Blue Cross believes that continuing the Direct Pay Premium Assistance Program for eligible subscribers, as part of an overall "return" to the community, will prove to be meaningful, effective, and sustainable. Specifically, we believe that the Direct Pay premium assistance is a significant step in contributing to the affordability of healthcare coverage costs for a disadvantaged segment of Rhode Islanders.

We fully appreciate, however, that the cost of healthcare is a much broader issue. Blue Cross alone cannot assure everyone access to healthcare coverage at rates they might personally find "affordable," let alone unilaterally control the underlying level of healthcare costs in the State and beyond. Ultimately all stakeholders in the Rhode Island healthcare arena must

participate in a much broader and more comprehensive effort if the level of healthcare costs generally, and affordability specifically, are to be materially altered. Nonetheless, we believe that continuing and expanding the Direct Pay Premium Assistance Program are steps that Blue Cross can take at this time, consistent with a measured "return" to the community, which will help some of those in greatest need of assistance with their healthcare premium rates.

In order to sustain the Direct Pay Premium Assistance Program over time, we must continue to be successful financially. Blue Cross must manage the company so that we compete effectively and realize operating gains; and we must be able to offer the products required to do so at appropriate rates based on sound actuarial practices and judgments.

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